AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE APRIL 29, 2003

AMENDED IN SENATE APRIL 10, 2003

SENATE BILL No. 130

Introduced by Senator Chesbro

February 5, 2003

An act to add Division 1.5 (commencing with Section 1180) to the Health and Safety Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 130, as amended, Chesbro. Health and care facilities: use of seclusion and behavioral restraints.

Existing law provides for the licensure and regulation of health facilities, including various types of hospitals that provide mental health treatment services, by the State Department of Health Services.

Existing law, the California Community Care Facilities Act, provides for the licensure and regulation of community care and residential facilities by the State Department of Social Services. Existing law authorizes these facilities to provide mental health treatment services.

Under existing law, the State Department of Mental Health is charged with the state administration of state hospitals for the mentally disordered.

Under existing law, these facilities are authorized to provide secure containment or use seclusion and restraints, as specified, on patients.

This bill would require the California Health and Human Services Agency to develop policies to reduce, and demonstrate leadership in reducing, the use of seclusion and behavioral restraints in facilities, as defined, and to provide oversight to accomplish these purposes. This

bill would require the secretary of the agency to coordinate efforts to meet the requirements of this bill by involving the State Department of Health Services, the State Department of Mental Health, and the State Department of Social Services, as well as other agencies and stakeholders, as determined by the secretary.

This bill would require the secretary to collect data, as specified, regarding the use of seclusion and behavioral restraints in these facilities, and to develop a system of data collection.

This bill would authorize specified facilities to use seclusion and behavioral restraints for behavioral emergencies only when a patient's behavior presents an imminent danger of serious harm to the patient or others, would require an initial assessment of each patient upon admission for these purposes, and would prohibit specified facilities from using specified types of seclusion and behavioral restraints. This bill would also require these facilities to conduct reviews, as specified, for each episode of the use of seclusion or behavioral restraint, to conduct debriefings, as specified, and to document the incident. This bill would also require these facilities to report, as specified, each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints.

This bill would provide that it shall not become operative, and that it is for display purposes only.

Vote: majority. Appropriation: no. Fiscal committee: ~~yes~~ *no*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) According to a Senate Office of Research report in 2002, the use of seclusion and behavioral restraints in psychiatric and medical facilities is known to be a dangerous practice that can, and sometimes does, result in serious injury, trauma, and even death.

(2) The federally mandated advocacy organization, Protection and Advocacy, Inc., reports that 22 people have died and one person has become persistently comatose while in seclusion or behavioral restraints in California psychiatric facilities since new federal regulations went into effect in July 1999.

(3) Protection and Advocacy, Inc., further reports that patients are at risk of positional asphyxiation when they are restrained in

a face down or ‘‘prone’’ position. This position can cause sudden cardiac arrhythmia or decreased oxygen delivery at a time of increased oxygen demand.

(4) The Harvard Center for Risk Analysis estimates that between 50 and 150 deaths occur nationally each year due to the use of seclusion and behavioral restraints in psychiatric and medical facilities.

(5) The RAND Corporation estimates that over 100,000 Californians are involuntarily committed to psychiatric facilities each year. Along with an unknown number of voluntarily committed patients, any one of them is at risk of being placed in seclusion and behavioral restraints.

(6) The United States General Accounting Office cites differing statewide standards as contributing to difficulties in obtaining accountability for the use of seclusion and behavioral restraints. California is among those states that lack statewide standards for the use of seclusion and behavioral restraints. State rules governing their use are different, depending on the type of facility, and are enforced by different state departments.

(7) California’s system for tracking the use of seclusion and behavioral restraints is inadequate. There is no method for tracking injuries caused by the use of seclusion and behavioral restraints. In addition, during the year 2000, 22 percent of the facilities that were required to report data submitted either an incomplete report or none at all.

(8) In 1997, the State of Pennsylvania launched comprehensive reforms in policies regarding the use of seclusion and behavioral restraints in nine state hospitals. Labeling seclusion and restraints as treatment failure, rather than treatment, Pennsylvania reduced the use of seclusion and restraints by 74 percent and the duration of time patients spent in seclusion and restraints by 96 percent over the next three years. The state reallocated existing funds, using no new tax dollars, and successfully reduced injuries to staff as well as to patients. In October 2000, Pennsylvania’s reform project was awarded the Harvard University Innovations in American Government Award.

(b) The Legislature further finds and declares all of the following:

(1) The use of seclusion and behavioral restraints is not treatment, and their use does not alleviate human suffering or

positively change behavior. In addition, when used, they are dangerous and dehumanizing to mental health inpatients.

(2) Inactivity, boredom, and confinement in noisy and crowded wards are significant contributors to frustration, conflict, and stress in psychiatric facilities, and lead to the problem of the use of seclusion and behavioral restraints.

(3) An ongoing commitment to varied, active, and stimulating choices of programming is important in addressing the problems of the use of seclusion and behavioral restraints in psychiatric facilities.

(4) The commitment of managers and staff of psychiatric facilities is essential to changing the culture of those facilities and reducing the use of seclusion and behavioral restraints, and providing a safer and more therapeutic environment for mental health patients in California.

(5) In order to achieve the goal of a reduction in the use of seclusion and behavioral restraints, California must utilize the best practices developed in other states, especially Pennsylvania, and use the most efficient modern resources to accomplish these goals, including computerized data collection and analysis, public access to this information on the Internet, strategies for organizational change, staff training in risk assessment, crisis prevention and intervention, patient debriefing models, and recovery-based treatment models.

(c) It is the intent of the Legislature in enacting this act to require a reduction in the use of seclusion and behavioral restraints in facilities.

SEC. 2. Division 1.5 (commencing with Section 1180) is added to the Health and Safety Code, to read:

DIVISION 1.5. USE OF SECLUSION AND BEHAVIORAL RESTRAINTS IN FACILITIES

1180. (a) The California Health and Human Services Agency shall, as the lead agency, develop policies to reduce, and shall demonstrate leadership in reducing, the use of seclusion and behavioral restraints in facilities described in subdivision (b), and shall provide oversight, as required, to accomplish the purposes of this division.

(b) The policy changes and oversight described in subdivision (a), shall apply to all facilities that utilize seclusion or behavioral restraints, including, but not limited to, state hospitals, the psychiatric units of general acute care hospitals, acute psychiatric hospitals, psychiatric health facilities, crisis stabilization units, community treatment facilities, group homes, skilled nursing facilities, and mental health rehabilitation centers.

(c) For purposes of this division, the following definitions apply:

(1) ''Mechanical restraint'' means the use of a mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a patient's body or restricts normal access to the patient's body, and that is used as a behavioral restraint.

(2) ''Physical restraint'' means the use of a manual hold to restrict freedom of movement of all or part of a patient's body, or to restrict normal access to the patient's body, and that is used as a behavioral restraint. ''Physical restraint'' also includes any staff-to-patient physical contact in which the patient unwillingly participates.

~~(3) ''Chemical restraint'' means a medication administered involuntarily to a patient to control the patient's behavior or to restrict the patient's freedom of movement, which medication is not a standard treatment for the patient's medical or psychiatric condition.~~

~~(4)~~

(3) ''Containment'' means a brief physical holding of a patient for the purpose of effectively gaining quick control of a patient who is aggressive or agitated or who is a danger to self or others.

~~(5)~~

(4) ''Secretary'' means the Secretary of the California Health and Human Services Agency.

(d) (1) The secretary shall coordinate efforts to meet the requirements of this division by involving appropriate state departments, including the State Department of Health Services, the State Department of Mental Health, and the State Department of Social Services, as well as other agencies and stakeholders, as determined by the secretary.

(2) The agencies or entities specified in paragraph (1) shall, upon the request of the secretary, provide information to the secretary regarding their leadership and efforts undertaken to reduce the use of seclusion and behavioral restraints, including, but not limited to, efforts to pursue federal funding for this purpose.

(3) The secretary shall oversee and coordinate the actions of the departments identified in paragraph (1), and shall collect detailed data on the use of seclusion and behavioral restraints in facilities described in subdivision (b), and on patient injuries or deaths that occur while in seclusion or behavioral restraints. The secretary shall make that information publicly available on the Internet.

(4) As funds become available, the secretary or his or her designee~~,~~ shall develop technical assistance and training programs to support the efforts of facilities to reduce or eliminate the use of seclusion and behavioral restraints in those facilities that utilize them.

(e) The secretary or his or her designee shall develop a system of mandatory, consistent, and publicly accessible data collection regarding the use of seclusion and behavioral restraints in all facilities described in subdivision (b) that utilize seclusion and behavioral restraints. This data shall be compiled on a basis of incidents per 1,000 patient days, in a manner that allows for standard statistical comparison. The secretary or his or her designee shall create and maintain a list of all facilities subject to these requirements. In addition, the secretary shall develop a mechanism for making this information publicly available on the Internet within 30 days of data collection, and for enforcement of these requirements. The secretary shall develop a system of penalties payable by any facility that does not meet these requirements.

(f) The secretary or his or her designee shall collect the following data on the use of seclusion and behavioral restraints:

(1) The number of deaths that occur while a patient is in seclusion or behavioral restraints, or where it is reasonable to assume that the death was proximately related to the use of seclusion or behavioral restraints.

(2) The number of serious injuries sustained by patients while in seclusion or subject to behavioral restraints. For purposes of this division, ‘‘serious injury’’ means any significant impairment of

the physical condition of a patient as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs, whether self-inflicted or inflicted by someone else.

(3) The number of staff injuries that occur during the use of seclusion or behavioral restraints.

(4) The number of incidents of seclusion.

(5) The number of incidents of use of behavioral restraints.

(6) The duration of time spent in seclusion.

(7) The duration of time spent subject to behavioral restraints.

(8) The use of involuntary emergency medication.

(9) Patient day information.

(g) Emergency rooms shall provide the secretary with the data required in subdivision (f), except for the patient day information specified in paragraph (9) of subdivision (f). In addition, the secretary shall formulate a workgroup to study the special issues regarding the use of seclusion and behavioral restraints in emergency room settings, and to make special recommendations in order to reduce the use of seclusion and restraints in those settings.

(h) The secretary shall assess the impact of staff injuries, sustained during the use of seclusion or behavioral restraints, on staffing costs and on workers' compensation claims and costs.

(i) The secretary or his or her designee shall review and minimize redundancies in paperwork requirements.

1180.1. A facility described in subdivision (b) of Section 1180 shall conduct an initial assessment of each patient upon admission to the facility, or as soon thereafter as possible. This assessment shall include input from the patient and from a family member, significant other, or person designated by the patient, if he or she desires. This assessment shall also include all of the following:

(a) A patient's advance directive regarding deescalation or the use of seclusion or behavioral restraints.

(b) Identification of early warning signs, triggers, and precipitants that cause a patient to escalate, and identification of the earliest precipitant of aggression for patients with a known or suspected history of aggressiveness, or patients who are currently aggressive.

(c) Techniques, methods, or tools that would help the patient control his or her behavior.

(d) Preexisting medical conditions or any physical disabilities or limitations that would place the patient at greater risk during restraint or seclusion.

(e) Any history of sexual or physical abuse.

1180.2. A facility described in subdivision (b) of Section 1180 may use seclusion or behavioral restraints on patients for behavioral emergencies only when a patient's behavior presents an imminent danger of serious harm to the patient or others.

1180.3. (a) A facility described in subdivision (b) of Section 1180 may not use either of the following on patients:

(1) A physical restraint or containment technique that obstructs a patient's respiratory airway or impairs the patient's breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back or places his or her body weight against the patient's torso or back.

(2) A pillow, blanket, or other item under or over the patient's face as part of a physical or mechanical restraint or containment process.

(b) A facility described in subdivision (b) of Section 1180 may not use physical or mechanical restraint or containment on a patient who has a known medical or physical condition, and where there is reason to believe that the use would endanger the patient's life or exacerbate the patient's medical condition.

(c) A facility described in subdivision (b) of Section 1180 may not use prone mechanical restraint on a patient at risk for positional asphyxiation as a result of one of the following known risk factors:

(1) Obesity.

(2) Pregnancy.

(3) Agitated delirium or excited delirium syndromes.

(4) Cocaine, methamphetamine, or alcohol intoxication.

(5) Exposure to pepper spray.

(6) Preexisting heart disease, including, but not limited to, an enlarged heart and other cardiovascular disorders.

(7) Respiratory conditions, including emphysema, bronchitis, or asthma.

(d) A facility described in subdivision (b) of Section 1180 shall avoid the deliberate use of prone containment techniques whenever possible. If prone containment techniques are used in an

emergency situation, a minimum of two staff members shall be involved in the restraint application. A third staff member shall observe the patient for any signs of physical duress throughout the use of prone containment. The staff member monitoring the patient shall not be involved in restraining the patient. The staff member monitoring the patient shall be trained in ensuring adequate patient respiration, circulation, and overall well-being. A staff member using prone containment on a patient shall roll or turn the patient from the prone position as soon as possible.

(e) A facility described in subdivision (b) of Section 1180 may not place a patient in a facedown position with hands held or restrained behind the patient's back.

(f) A facility described in subdivision (b) of Section 1180 may not use physical restraint or containment as an extended procedure, and the use of physical restraint or containment may not exceed 10 minutes.

(g) A facility described in subdivision (b) of Section 1180 shall keep under constant, face-to-face human observation a person who is in seclusion or in any type of behavioral restraint.

(h) A facility described in subdivision (b) of Section 1180 shall afford to patients who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the patient and others, and must use the least number of restraint points.

~~(i) A facility described in subdivision (b) of Section 1180 may not use chemical restraints.~~

(i) A person in a facility described in subdivision (b) of Section 1180 has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the patient's freedom of movement, if that drug is not a standard treatment for the patient's medical or psychiatric condition.

1180.4. (a) A facility described in subdivision (b) of Section 1180 shall conduct a clinical, administrative, and quality review for each episode of the use of seclusion or behavioral restraints.

(b) A facility described in subdivision (b) of Section 1180 shall, within 24 hours after the use of seclusion or behavioral restraints, conduct a debriefing regarding the incident with the patient, or the

patient's family member, domestic partner, or advocate if the patient requests, the staff members involved in the incident, and a representative of the senior or management staff of the facility, to discuss how to avoid a similar incident in the future. The purposes of the debriefing shall be to do all of the following:

(1) Assist the patient to identify the precipitant of the incident, and suggest methods of more safely and constructively responding to the incident.

(2) Assist the staff to understand the precipitants to the incident, and develop alternative methods of helping the patient avoid or cope with those incidents.

(3) Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.

(4) Provide an opportunity for both patients and staff to assess the appropriateness and efficacy of staff response during the emergency, and attend to the patient's feelings.

(5) Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and hospital policies.

(c) The facility shall, in the debriefing, provide both the patient and staff the opportunity to discuss the circumstances resulting in the use of seclusion or behavioral restraints, and strategies to be used by the staff, the patient, or others that could prevent the future use of seclusion or behavioral restraints.

(d) The facility staff shall document in the patient's record that the debriefing session took place, and shall include in that documentation the names of staff members who were present for the debriefing, the names of staff who were excused from the debriefing, and any changes to the patient's treatment plan that resulted from the debriefing.

1180.5. A facility described in subdivision (b) of Section 1180 shall report each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints. This report shall be made to the agency designated in Section 4900 of the Welfare and Institutions Code no later than the close of the business day following the death or injury. The report shall include the name of the patient involved, and the name, street address, and telephone number of the facility.

SEC. 3. Notwithstanding any other provision of this act, Section 2 of this act shall not become operative, and is for display purposes only.

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